MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00531 Reg. Dist. No. 00528

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Marbury
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ESTHER Middle Last BAILEY
4. DATE OF DEATH: Month January Day 1 Year 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Nov. 14, 1900
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (State or foreign country): Harford County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Arthur Hanna
14. MOTHER'S MAIDEN NAME: Catherine Stinchcomb
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Yes 217-34-1161
INFORMANT: Miss. Mary U. Hanna -Sister- Address: Marbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cereberal Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Was in Auto accident 8/8/61 & sustained Rib fractures Hemopneumothorax
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 61, to 1/1, 19 62 that I last saw the deceased alive on 12/ , 19 61, and that death occurred at 6:30 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state): Rt 1 Box 50
DATE SIGNED: Jan. 2, 1962
ACTUAL SIGNATURE: Frank A Susan M.D.
PHYSICIAN'S NAME (Type): Frank A. Susan, M.D. Glymont Medical Building, Indian Head, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 2 1962
22c. NAME OF CEMETERY OR CREMATORY: Gorsebury Methodist Cemetery
22d. LOCATION (City, town, or county) (State): Abbington, Harford Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hubert Funeral Home, Inc. LaPlata, Md.
24a. RECD BY REGISTRAR DATE: JAN 5 62
24b. REGISTRAR'S SIGNATURE: Clifton L. Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00532

CERTIFICATE OF DEATH

00529

1. **PLACE OF DEATH**
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT VICTORIA
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MT VICTORIA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: MARY Middle: ELEANOR Last: BARBER

4. DATE OF DEATH: Month: 1 Day: 25 Year: 1962

5. SEX: F

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 5, 1868

9. AGE (In years last birthday): 93 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: YATES BARBER

14. MOTHER'S MAIDEN NAME: ELIZA CRANE MORGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: B.L. GROVE, 3333 Stephenson Pl. N.W, WASH. 15, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEN. VISCERAL FAILURE

4 50.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CEN. ART SCLEROSIS

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19 5.. to ....., 19 62, that (I) (we) last saw the deceased alive on Jan 10 19 62 and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: E.J. Edelen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): E.J. EDELEN

22d. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-27-62

23c. NAME OF CEMETERY OR CREMATORY: CHRIST CHURCH CEM.

23d. LOCATION (City, town or county) (State): WAYSIDE, MD.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: THE HUNTT FUNERAL HOME, WALDORF, MD.

25a. REC'D BY REGISTRAR DATE: JAN 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00533 06530

1. **PLACE OF DEATH** a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: Min.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PHYSICIANS MEMORIAL HOSP.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X POTOMAC HEIGHTS
d. STREET ADDRESS: 81 CIRCLE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First AGNES Middle MARY Last BASTAIN

4. **DATE OF DEATH**: Month Jan Day 2 Year 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 25, 1910
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: LORENZO BRYANT
14. MOTHER'S MAIDEN NAME: MARY LONG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-28-6165
17. INFORMANT: PERRY BASTAIN, 81 CIRCLE AVE, POTOMAC HGTS, MD. Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH: 6 Months
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
20 wk

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: F. M. Johnson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-2-62
22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.
22d. ADDRESS: LA PLATA, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN 6. 1962
23c. NAME OF CEMETERY OR CREMATORY: TRINITY MEMORIAL
23d. LOCATION (City, town, or county) (State): WALDORF, MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McHuntFuneral Home, WALDORF, MD.
25a. REC'D BY REGISTRAR DATE JAN 11 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66534 — 00531

1

M

1. PLACE OF DEATH a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LA PLATA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle N. — Last CAMPBELL

4. DATE OF DEATH: Month Jan — Day 3 — Year 1962

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb 15, 1893

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: WILLIAM CAMPBELL

14. MOTHER'S MAIDEN NAME: ELIZABETH BUTLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: FRANCES CAMPBELL, LA PLATA, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-2 1962 to 1-3 1962 that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: F. M. Johnson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-3-62

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.

22d. ADDRESS: La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-6-62

23c. NAME OF CEMETERY OR CREMATORY: ST MARYS

23d. LOCATION (City, town, or county) (State): BRYANTOWN, MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hunt Funeral Home, WALDORF, MD.

25a. REC'D BY REGISTRAR DATE: JAN 11 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the funeral or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00535 — 00532

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X NANJEMOY
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BROADIE — Middle MAC — Last CARPENTER

4. DATE OF DEATH: Month JAN — Day 14 — Year 1962

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: FEB. 14, 1889 — 9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER — 10b. KIND OF BUSINESS OR INDUSTRY: FARMING — 11. BIRTHPLACE (State or foreign country): VIRGINIA — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN HENRY CARPENTER — 14. MOTHER'S MAIDEN NAME: NANCY LEE BURCHELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: EDITH CARPENTER, NANJEMOY, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerosis — 10 years
DUE TO (c): Hypertension — " "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1958 to Jan 14, 1962, that (I) (we) last saw the deceased alive on Jan 14 1962 and that death occurred at 12:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: F. M. Johnson — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 1-15-62

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON MD — 22d. ADDRESS: La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 1-16-62 — 23c. NAME OF CEMETERY OR CREMATORY: NANJEMOY BAPTIST — 23d. LOCATION (City, town, or county) (State): NANJEMOY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hunt Funeral Home, WALDORF, MD. — 25a. REC'D BY REGISTRAR DATE: JAN 18 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00536 **CERTIFICATE OF DEATH** 00533

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Indian Head
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Charles.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Indian Head.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First HELEN Middle EMILY Last COX

4. DATE OF DEATH: Month JANUARY Day 24 Year 1962

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8 July 1884

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DAIRY FARMER

10b. KIND OF BUSINESS OR INDUSTRY: AGRICULTURE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: SAMUEL COX

14. MOTHER'S MAIDEN NAME: ALICE M. WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-38-4821

17 INFORMANT Address: HENRY L. THOMAS, BRYANS ROAD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Embolism — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes.

DUE TO (b): Thrombophlebitis, right leg, postphlebitic — 2 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Hypertensive Cardio-vascular disease — 2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 23 November 1961, to 24 January, 1962, that (I) (we) last saw the deceased alive on 23 Jan 1962, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

22a SIGNATURE: A. Wooddy. MD — M D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 24 Jan 62

22c. PHYSICIAN'S NAME (Type): ARTHUR O. WOODDY, MD

22d. ADDRESS: JARWOOD CLINIC LA PLATA, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-27-62

23c NAME OF CEMETERY OR CREMATORY: Bumpy Oak

23d. LOCATION (City, town, or county) (State): Pomonkey, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hunter Funeral Home, WALDORF, MD.

25a. REC'D BY REGISTRAR DATE: JAN 30 '62

25b REGISTRAR'S SIGNATURE: Ruth S. Kirma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00537 00534

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Plata
d STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mynn Middle: Shindel Last: HAUPT

4. DATE OF DEATH: Month: JAN Day: 8 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 13, 1871

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Sunbury, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel W. Shindel

14. MOTHER'S MAIDEN NAME: Elizabeth L. Shindel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: Mrs. Elizabeth Rossiter - La Plata, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of breast — 10 years

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from Aug 1961 to Jan 8 1962 that (I) (we) last saw the deceased alive on Dec 1961, and that death occurred at 9:15 AM from the causes and on the date stated above.

22a SIGNATURE: F. Johnson MD M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 1-9-62

22c PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.

22d ADDRESS: LA PLATA Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/11/1962 — 23c NAME OF CEMETERY OR CREMATORY: Pomfret Manor Cemetery — 23d LOCATION (City, town, or county) (State): Sunbury, Pennsylvania

24 FUNERAL DIRECTOR'S SIGNATURE: Arehart Funeral Home, Inc. — ADDRESS: Arehart Funeral Home, Inc. La Plata, Maryland

25a REC'D BY REGISTRAR — DATE: JAN 12 '62 — 25b REGISTRAR'S SIGNATURE: Evelyn L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00538

00535

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grayton
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Grayton
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Mary — Middle Warfield — Last Higgins

4. DATE OF DEATH: Month Jan. — Day 20 — Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 26, 1863

9. AGE (In years last birthday): 98 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T. Warfield

14. MOTHER'S MAIDEN NAME: Rachel V. Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Mrs. Wallace Clark, Same as 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from November, 1960 to January 20, 1962 that (I) (we) last saw the deceased alive on Jan 20 1962 and that death occurred at 9:00 P.M. from the couses and on the date stated above.

22a. SIGNATURE: Wilbur W Martin M.D.

ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) WILBUR W MARTIN

22d. ADDRESS: 100 Williamsburg DR. Silver Spring, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-23-62

23c. NAME OF CEMETERY OR CREMATORY: Goshen

23d. LOCATION (City, town, or county) (State): Goshen, Montgomery, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR — DATE JAN 24 '62

25b. REGISTRAR'S SIGNATURE: C. E. Moore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00539

CERTIFICATE OF DEATH

00536

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Plains
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: William Middle: M. Last: Hodges

4. DATE OF DEATH: Month: Jan. Day: 3 Year: 1962

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 13, 1878

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Pomfret Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Hodges

14. MOTHER'S MAIDEN NAME: Georgianna Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: yr 213-38-2752

17. INFORMANT: Mrs. Alfred Hill Address: White Plains Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Cerebral Thrombosis — 1 month
DUE TO (c): Central Arterio Sclerosis — Fundamental

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 16 1961 to January 3 1961, that (I) (we) last saw the deceased alive on Jan 3 1962, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William J Kurz M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/4/62

22c. PHYSICIAN'S NAME (Type): William J. Kurz MD

22d. ADDRESS: La Plata, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-6-62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Rest cem.

23d. LOCATION (City, town, or county) (State): La Plata, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hunt Funeral Home ADDRESS: Waldorf Md.

25a. REC'D BY REGISTRAR DATE: JAN 11 '62

25b. REGISTRAR'S SIGNATURE: Irma L. Finus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00540 — 00537

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Port Tobacco
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Elroy — Last: Keys

4. DATE OF DEATH: Month: Jan — Day: 5 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 12, 1961

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months: 1 — Days: 24 — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LeRoy W. Gray

14. MOTHER'S MAIDEN NAME: Inez Gertrude Sims

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Le Roy Gray, ~~Port~~ Tobacco, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b):
DUE TO (c): Acute Gastro Enteritis — 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/3/1962 to 1/5/1962, that (I) (we) last saw the deceased alive on 1/4/1962 and that death occurred at 8 A M, from the causes and on the date stated above

22a. SIGNATURE: William J. Kurz M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): WILLIAM J. KURZ M.D.

22d. ADDRESS: LA PLATA MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-6-62

23c. NAME OF CEMETERY OR CREMATORY: St Catherines

23d. LOCATION (City, town, or county) (State): Mc Conchie, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Huntt Funeral Home, Waldorf, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 11 '62

25b. REGISTRAR'S SIGNATURE: C. L. Kimes

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be forwarded with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

2266288084

1

FOR STATE HEALTH DEPT.

IO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00541 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00538

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN this place: D.C.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PHYS. CIANS MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDWARD — Middle: FRANCIS — Last: NORRIS

4. DATE OF DEATH: Month: 1 — Day: 1 — Year: 1962

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 27, 1901

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: ODD JOBS

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES MORRIS

14. MOTHER'S MAIDEN NAME: CAROLYN WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): YES WWI

16. SOCIAL SECURITY NO.: 216-07-6262

17. INFORMANT — Address: FLOSSIE NORRIS, BEL AIR, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 42 C, 1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 1-1-62

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature]

EXAMINER'S NAME (Type): E. J. FEDDEN, M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 1-2-62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-4-62

22c. NAME OF CEMETERY OR CREMATORY: ST IGNATIUS

22d. LOCATION (City, town, or country) (State): CHAPEL POINT, MD

23. FUNERAL DIRECTOR — ADDRESS: HUNTT FUNERAL HOME, WALDORF, MD.

24a. REC'D BY REGISTRAR — DATE: JAN 11 '62

24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. (0539) 00542

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rison
c. LENGTH OF STAY IN 1b: 11yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rison
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle William — Last Perry

4. DATE OF DEATH: Month Jan. — Day 16 — Year 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 15, 1861

9. AGE (In years last birthday): 100 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: Own shop

11. BIRTHPLACE (State or foreign country): Louisa County Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Perry

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578260205

17. INFORMANT: Mrs Harry Keeton — Address: Box 15 P.O. Rison Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Heart Disease
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 61, to Jan 16, 19 62, that I last saw the deceased alive on Jan. 15, 19 62, and that death occurred at 5 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank A. Jason M.D.
ADDRESS (Street, city or town, state): Glymont Medical Bldg. Rt 1 Box 50 Indian Head Md.
DATE SIGNED: 1/16/62
PHYSICIAN'S NAME (Type): Frank A. Jason M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/20/1962
22c. NAME OF CEMETERY OR CREMATORY: Local (ship to)
22d. LOCATION (City, town, or county) (State): Madison, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. Ernest Jarvis
ADDRESS: W. Ernest Jarvis Co. 1432 You Street, N.W.

24a. REC'D BY REGISTRAR DATE: JAN 22 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00543 — Reg. Dist. No. 00540

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pisgah Md
c. LENGTH OF STAY IN 1b: 18 Mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pisgah
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Herman (Name) Middle Pisgah Last
4. DATE OF DEATH: Month 1 Day 2 Year 62 — 19

5. SEX: Male — 6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-11-1880
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 157-12-4466
17. INFORMANT: Gertrude Burr (Daughter) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio-Sclerosis — Indefinite
DUE TO (c): Senility
4 - c - b

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-1-61, 19__ to 1-2-62, 19__, that I last saw the deceased alive on 1-2-62, 19__, and that death occurred at 9a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James Enders M.D. — ADDRESS (Street, city or town, state): 17 Patterson Ave — DATE SIGNED:
PHYSICIAN'S NAME (Type): JAMES E ANDERSON — Medical Arts Mel

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-3-62
22c. NAME OF CEMETERY OR CREMATORY: Holy Name
22d. LOCATION (City, town, or county) (State): Jersey City N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: Urkart Inc — ADDRESS: Loyola Md.
24a. REC'D BY REGISTRAR DATE: JAN 5 '62
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00544 — 00541

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA RURAL
c. LENGTH OF STAY: 10 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD — b. COUNTY: CHAS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: ELIZABETH — Middle: SUSANA — Last: QUEEN

4. DATE OF DEATH: Month: 1 — Day: 23 — Year: 1962

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 12-25-1876

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWF

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (County & State, or foreign country): BELAIR MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: NED PROCTOR

14. MOTHER'S MAIDEN NAME: SALLY ANNE THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MRS. PROCTOR — Address: MARBURY MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEN. VISCERAL FAILURE
DUE TO (b): CEN. ARTERIO SCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 MOS. / 20 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1942, 19, to 1-18, 1962, that (I) (we) last saw the deceased alive on 1-18, 62, and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E.J. Edelen — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 1-24-62

22c. PHYSICIAN'S NAME (Type): E.J. EDELEN — 22d. ADDRESS: LA PLATA MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 1-27-62 — 23c. NAME OF CEMETERY OR CREMATORY: ST CATHERINES — 23d. LOCATION (City, town or county) (State): MC CONCHIE, MD.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: The Huntt Funeral Home, Waldorf, MD.

25a. REC'D BY REGISTRAR — DATE: JAN 30 '62 — 25b. REGISTRAR'S SIGNATURE: Cecilia B. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00545 01542

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALYCE Middle E. Last ROBEY

4. DATE OF DEATH: Month JAN. Day 30 Year 1962

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 29, 1906
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN E. GUY
14. MOTHER'S MAIDEN NAME: MARY B. GRAVES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-16-8090
17. INFORMANT: Address: Allison ROBEY, WALDORF, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
DUE TO (b): Hypertensive Cardiovascular Disease — 5 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1954, 19__, to Jan. 30, 1962, that (I) (we) last saw the deceased alive on Dec. 30 1961, and that death occurred at 2-A M, from the causes and on the date stated above.

22a. SIGNATURE: J. Parran Jarboe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-30-62
22c. PHYSICIAN'S NAME (Type): J. PARRAN JARBOE M.D.
22d. ADDRESS: La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-1-62
23c. NAME OF CEMETERY OR CREMATORY: ST PETERS
23d. LOCATION (City, town, or county) (State): WALDORF MD.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: The HUNTT Funeral Home, WALDORF, MD.
25a. REC'D BY REGISTRAR DATE: FEB 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Patient under care at Dr. Dodson's office at Waldorf since Jan. 29/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00546

CERTIFICATE OF DEATH

00543

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: G. — Last: Robey
4. DATE OF DEATH: Month: Jan. — Day: 7, — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 22, 1880
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jessie Cox
14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Raymond Robey, Waldorf, Maryland — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.4
DUE TO (c): Anemia — years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Stomach Trouble
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 16 1962 to Jan 7 1962, that (I) ~~(we)~~ last saw the deceased alive on Jan 7 1962 and that death occurred at 2:30 PM from the causes and on the date stated above.

22a. SIGNATURE: Vaheh M. Seron MD M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 1/7/62
22c. PHYSICIAN'S NAME (Type): VAHEH M. SERON M.D.
22d. ADDRESS: Waldorf Md

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-10-62
23c. NAME OF CEMETERY OR CREMATORY: St Josephs
23d. LOCATION (City, town, or county) (State): Pomfret, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Huntt Funeral Home, Waldorf, Md.
25a. REC'D BY REGISTRAR DATE: JAN 11 '62
25b. REGISTRAR'S SIGNATURE: Caroline L. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00547

CERTIFICATE OF DEATH

Item 1 Film G305 1/16/62 jwk

1. PLACE OF DEATH
a. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata P.O.
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): in private home

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
e. STATE: Md
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks Point
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: LILLIAN Middle: C Last: SHORTER

4. DATE OF DEATH: Month: Jan Day: 3 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: March 31, 1885

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H W

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (County & State, or foreign country): Charles Co, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Thomas Fowler

14. MOTHER'S MAIDEN NAME: Sarah Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown): No

16. SOCIAL SECURITY NO: None.

17. INFORMANT: Mrs Earl Hill Address: Rock Point

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-10, 1961 to 1, 19 62 that (I) (we) last saw the deceased alive on 1-2, 19 62 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: E. J. Edelen M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/5/1962

22c. PHYSICIAN'S NAME (Type): E. J. EDELEN

22d. ADDRESS: La Plata Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-6-62

23c. NAME OF CEMETERY OR CREMATORY: Holy Ghost

23d. LOCATION (City, town or county) (State): Pisue Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Chehart Inc ADDRESS: La Plata Md

25a. REC'D BY REGISTRAR DATE: JAN 12 '62

25b. REGISTRAR'S SIGNATURE: Lindsay S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00548

CERTIFICATE OF DEATH

Item 11 Film C306 2/8/62 ink

111545

1 PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: 13days.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hospital.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LA PLATA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Loucile Middle H Last SOLLARS

4. DATE OF DEATH: Month JAN Day 26 Year 1962

5 SEX: Female. 6 COLOR OR RACE: W 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 Oct 1906

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POSTAL CLERK

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Post Office

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS METCALF

14. MOTHER'S MAIDEN NAME: ELIZABETH JEROLDINE BURCH.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-16-3187

17. INFORMANT: MRS ELIZABETH S. RAYMOND Address: LA PLATA MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Metastic Carcinoma Generalized. — 8 Months

DUE TO (c): Carcinoma, breast — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 1961, to 26 Jan 1962 that (I) (~~not~~) last saw the deceased alive on 24 Jan 1962 and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A.O. Wooddy M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 26 Jan 62

22c PHYSICIAN'S NAME (Type): ARTHUR O. WOODDY MD

22d ADDRESS: LA PLATA MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 1/29/62.

23c NAME OF CEMETERY OR CREMATORY: ST. IGNATIUS CEMETERY

23d LOCATION (City, town, or county) (State): BEL ALTON, MARYLAND.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Urehart Funeral Home, Inc. La Plata, Md.

25a. REC'D BY REGISTRAR, DATE: FEB 5 62

25b. REGISTRAR'S SIGNATURE: Clifton L. Mc W

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be rea... by the ho... or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and ... should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00549

CERTIFICATE OF DEATH

Reg. Dist. No. 11546

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- LAPLATA
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xRural La Plata.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle EDWIN Last SWANN

4. DATE OF DEATH: Month JAN. Day 5, Year 1962

5. SEX: Male

6. COLOR OR RACE: NEGRO

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 22, 1887

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWIN SWANN

14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: INEZ BROOKS Address: GLEN BURNIE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 12 min
DUE TO
(b): Generalized Carcinoma — 2 months
DUE TO
(c): Carcinoma Sigmoid — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 Dec, 1961, to Jan, 1962, that I last saw the deceased alive on 29 Dec, 1961, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A Wooddy M.D. ADDRESS (Street, city or town, state): JARWOOD CLINIC DATE SIGNED: 8 Jan 62

PHYSICIAN'S NAME (Type): ARTHUR O. WOODDY LA PLATA, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-9-62

22c. NAME OF CEMETERY OR CREMATORY: ST IGNATIUS

22d. LOCATION (City, town, or county) (State): CHAPEL POINT, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The HUNTT Funeral Home, WALDORF, MD.

24a. REC'D BY REGISTRAR DATE: JAN 11 '62

24b. REGISTRAR'S SIGNATURE: C.L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00550 Items 2,5,9 & 13 011547

1 PLACE OF DEATH a. COUNTY: CALVERT MARYLAND | 2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE (Md) b. COUNTY CHARLES

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FOWLER'S MILL | c. LENGTH OF STAY IN 1b: 1 yr. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): P. O. PORT KINGSVILLE

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: LANCASTER Middle: TEMPLEMON Last: Templemon | 4. DATE OF DEATH Month: 1 Day: 13 Year: 1962

5. SEX: MALE | 6. COLOR OR RACE: NEGRO | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH: unknown 1893 | 9 AGE (In years last birthday) 68 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED | 10b. KIND OF BUSINESS OR INDUSTRY: FARMING | 11. BIRTHPLACE (State or foreign country): MARYLAND | 12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: LANCASTER TEMPLEMON | 14 MOTHER'S MAIDEN NAME: ANNIE GAMBLE

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW II | 16. SOCIAL SECURITY NO. | 17 INFORMANT Address: MRS. MARY E. TEMPLEMON, Port Kingsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CA PROSTATE

1777

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 19 62 to Jan 13 19 62 that (I) (we) last saw the deceased alive on Jan 13 19 62 and that death occurred at 4 P.M. from the causes and on the date stated above

22a SIGNATURE: E. J. Edelen M.D. | ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ | 22b DATE SIGNED 1/16/62

22c PHYSICIAN'S NAME (Type): E. J. EDELEN | 22d ADDRESS: PARK AVE. MD.

23a BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 25a. REC'D BY REGISTRAR DATE JAN 18 '62 | 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] page 4 may be rep[illegible] by the ho[illegible] or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] ould be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00551

CERTIFICATE OF DEATH

Inf. from birth certificate 1/26/62 jwk 00548

1 PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PHYSICIANS' MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St.Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mechanicsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SIDNEY Middle JOSEPH Last TIPPETT

4. DATE OF DEATH: Month JANUARY Day 23 Year 1962

5. SEX: MALE
6. COLOR OR RACE: W-US.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-21-62
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days 2
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENFANT
10b. KIND OF BUSINESS OR INDUSTRY: ENFANT
11. BIRTHPLACE (State or foreign country): U.S. (MARYLAND)
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOSEPH ELWOOD TIPPETT
14. MOTHER'S MAIDEN NAME: MARY HELEN TURNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: MARY HELEN TURNER TIPPETT; MECHANICSVILLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HYALINE MEMBRANE DISEASE, LUNGS — INTERVAL BETWEEN ONSET AND DEATH: 48 hours.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): PREMATURITY (6 3/4 MONTHS)
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a m p m Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from 1/21, 1962 to 1/23, 1962 that (I) (~~we~~) last saw the deceased alive on 1/23 1962 and that death occurred at 11:36 A.M., from the causes and on the date stated above.

22a SIGNATURE: John H. Griffin M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 1/23/62
22c. PHYSICIAN'S NAME (Type): John H. Griffin
22d. ADDRESS: Hughesville, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 1-23-62
23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart
23d LOCATION (City, town, or county) (State): Brathwood Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wilbert Inc Leonardtown Md
25a REC'D BY REGISTRAR DATE JAN 26 '62
25b. REGISTRAR'S SIGNATURE

12082

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00552

CERTIFICATE OF DEATH

111549

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Plata, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: A. — Last: Wallace

4. DATE OF DEATH: Month: January — Day: 20 — Year: 1962

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/1/37

9. AGE (In years last birthday): 25 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Horace Wallace

14. MOTHER'S MAIDEN NAME: Margaret Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Margaret Wallace — Address: La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 28 hours.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19 19 62 to Jan. 20 19 62 that (I) (we) last saw the deceased alive on Jan. 20 19 62, and that death occurred at 11:55 ☐ AM ☐ from the causes and on the date stated above.

22a. SIGNATURE: F Johnson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-20-62

22c. PHYSICIAN'S NAME (Type): Frederick M. Johnson, M.D.

22d. ADDRESS: La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: January 23/62

23c. NAME OF CEMETERY OR CREMATORY: Christ Episcopal

23d. LOCATION (City, town, or county) (State): La Plata, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: George G. Kelson

ADDRESS: Aquasco, Md.

25a. REC'D BY REGISTRAR DATE: JAN 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00553

CERTIFICATE OF DEATH

Reg. Dist. No. 01550

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marbury.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First John Middle Cleveland Last Wright

4. DATE OF DEATH: Month Jan Day 6 Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 5, 1885

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Man

10b. KIND OF BUSINESS OR INDUSTRY: U S Gov.

11. BIRTHPLACE (State or foreign country): Montgomery Md.

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Sabra Wright

14. MOTHER'S MAIDEN NAME: Mary Allen.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Mrs Mary Wright Address: Marbury.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Heart Desease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 43 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec 53, 19__, to Dec 20, 1961, that I last saw the deceased alive on Dec 20, 1961, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank A. Susan M.D.

ADDRESS (Street, city or town, state): Rt. 1 Box 50

DATE SIGNED: 1/6/62

PHYSICIAN'S NAME (Type): Frank A. Susan M.D. Indian Head Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-8-62

22c. NAME OF CEMETERY OR CREMATORY: Monjemon Baptist

22d. LOCATION (City, town, or county) (State): Monjemon Md

23. FUNERAL DIRECTOR'S SIGNATURE: Richard Pat

ADDRESS: Laplata Md.

24a. REC'D BY REGISTRAR DATE: JAN 12 '62

24b. REGISTRAR'S SIGNATURE: Clifton S. Kenny

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58